STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING _____ B. WING _____	C 06/23/2016

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SIGNATURE HEALTHCARE OF MADISON	431 LARKIN SPRING RD MADISON, TN 37115

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F 000	INITIAL COMMENTS During the complaint investigation of #38942 and #38965, conducted on 6/7-9/16 and 6/21-23/16, at Signature Healthcare of Madison, no deficiencies were cited in relation to the complaint #38965 under 42 CFR PART 483, Requirements for Long Term Care Facilities. Deficient practices were cited for complaint #38942.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	**F278** **483.20 ASSESSMENT ACURACY/COORDINATION/ CERTIFIED** **Plan of correction:** 1. Quarterly Minimum Data Set (MDS) dated 2/15/2016 and Annual MDS dated 5/7/2016 were modified per MDS Coordinator on 6/9/2016 for resident #2 to accurately identify the Haldol as an anti-psychotic medication. 2. Current residents receiving an anti-psychotic medication were audited on 7/11/2016 by the DON, ADON, and MDS coordinator to ensure that the most current MDS accurately identifies the use of anti-psychotic medication.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Sam Dozier — Administrator — 7/15/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately identify the medication classification for 1 (Resident #2) of 14 residents reviewed. The findings included: Medical record review revealed Resident #2 was admitted to the facility on 4/30/15 with diagnoses including Cerebrovascular Accident, Hemiplegia of the Dominant Side, Right Above Knee Amputation, Dementia, Adjustment Disorder, Pseudo-Bulbar Affect, Depression, and Psychotic Disorder with Delusion. Further review revealed the resident was discharged from the facility on 5/31/16. Medical record review revealed the physician telephone order dated 9/28/15 and continued to the 5/31/16 discharge for "...Ativan (anti-anxiety) 1 milligram (mg)/Haldol (anti-psychotic) 2 mg per milliliter (ml). Apply 1 ml Ativan/Haldol Gel topically to inner wrist two times daily..." Medical record review of the Annual Minimum Data Set (MDS) dated 5/7/16 revealed Resident #2 had received administration of anti-anxiety and anti-hypnotic medication for the past 4 days. A Quarterly MDS dated 2/15/16 revealed Resident #2 had received administration of an anti-anxiety medication for the past 7 days. Interview with the MDS Nurse #1 on 6/8/16 at 8:50 AM in the conference room confirmed the	F 278	3. An in-service conducted by DON, ADON, SDC for the RN's and LPN's responsible for submitting Material Data Sets to be completed by 8/5/2016 regarding appropriate anti-psychotic medication identification and appropriate coding in the MDS assessment. 4. The DON will be responsible for this process. Before submission of an MDS assessment, the DON will review psychoactive medication coding on MDS assessments to ensure accuracy for all MDS assessments x 3 months. DON will take findings to QAPI for review and recommendations monthly x 3 months. **Completion Date: August 5, 2016**	

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F 278	Continued From page 2 facility failed to accurately identify the Haldol as an anti-psychotic medication on the 2/15/16 and 5/7/16 MDS.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, interview and observation the facility failed to follow the physician order for Coumadin (anti-coagulant medication) administration for 1 (Resident # 9); failed to follow the physician order to administer oxygen while on a CPAP (Continuous Positive Airway Pressure) for 1 (Resident #1), and failed to administer Dilantin (seizure medication) as ordered for 1 (Resident #1) of 14 residents reviewed. The findings included: Medical record review revealed Resident #9 was admitted to the facility on 4/25/16 and readmitted to the facility on 6/16/16 with diagnoses including Acute Osteomyelitis, Morbid Obesity, Chronic Obstructive Pulmonary Disease, and Aortocornonary Bypass Graft. Medical record review of the physician telephone order dated 5/13/16 revealed "...1. D/C [discontinue] Coumadin 2.5 mg [milligrams]. 2. Coumadin 3.0 mg PO QD [by mouth every day]..."	F 281	**F281** **483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **Plan of correction:** 1. a. Medication Error was completed for Resident #9 on 5/13/2016. Order received to discontinue Coumadin per NP on 6/17/16. b. Order to bleed in 2L oxygen per CPAP for Resident #1 was discontinued by MD on 6/22/16. c. Medication Error was completed for Resident #1 on 6/24/2016. Order was written to DC Dilantin on 12/31/2015 and remains discontinued. 2. a. No other residents in facility currently have an order to administer Coumadin at this time.	

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F 281	Continued From page 3 Medical record review of the physician telephone order dated 5/16/16 revealed "...1. Coumadin 3 mg QHS [every bedtime]..." Medical record review of the May 2016 Medication Administration Record (MAR) revealed no documentation of the administration of the Coumadin 3.0 mg from 5/13/16 through the 5/16/16 telephone order. Interview with the Director of Nursing, on 6/22/16 at 1:15 PM in the conference room, confirmed the facility failed to follow the physician order on 5/13/16 to administer the Coumadin 3.0 mg PO QD for 3 days. Medical record review revealed Resident #1 was admitted to the facility on 12/17/14 and re-admitted on 11/13/15 with diagnoses of Adult Failure to Thrive, Dementia, Diabetes Mellitis Type 2, Muscle Weakness, Dysphagia, Aphasia, Gastrostomy, Hemiplegia following Cerebral Vascular Disease, and Hypertension. Medical record review of the Physicians Order dated 1/20/15 revealed "...CPAP(Continuous Positive Airway Pressure) 8 cm (centimeters) H2O (water), Bleed in O2 (oxygen) at 2 LPM (liters per minute) while sleeping..." Medical record review of the September 2015 and ongoing 6/22/16 MAR revealed "...CPAP 8 cm H2O, Bleed in O2 at 2 LPM while sleeping..." Medical Record Review of the Care Plan dated 1/21/15 revealed Resident #1 had Pulmonary Condition/diagnosis and had potential for difficulty breathing, resident had CPAP. Intervention dated	F 281	b. No other residents in facility currently have an order to administer/bleed oxygen per CPAP machine. c. All current residents receiving anti-seizure medications will be audited by DON and ADON by 7/15/2016 to ensure appropriate dose/duration of therapy for medication administration are accurate. 3. a, b, c. An in-service conducted by DON and SDC for the RN's and LPN's on staff/all shifts to be completed by 8/5/2016 regarding Order Entry, Medication Administration, and Following MD orders. New orders written by MD/NP will be brought to clinical meeting each morning by DON and ADON, to be reviewed with IDT and compared to order entry in EZ-MAR system. Medication discontinuation reports will be audited daily by DON, ADON, or designee to ensure order discontinuation is appropriate.	

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F 281	Continued From page 4 1/21/15 for nursing revealed CPAP as ordered. Interview with LPN (Licensed Practical Nurse) #3 on 6/22/16 at 9:25 AM at the East nurses station stated LPN #3 wasn't sure if the resident had O2 on his CPAP. Telephone interview with the daughter of the resident on 6/22/16 at 9:47 AM stated the CPAP machine was Resident #1's personal machine and he had never received oxygen through his CPAP machine. Telephone interview with LPN #1 on 6/22/16 at 10:45 AM stated Resident #1 never received oxygen with the CPAP since she started to work here in 5/2016. Telephone interview with LPN #4 on 6/22/16 at 11:30 AM stated the resident never received oxygen with the CPAP machine. Telephone interview with the facility physician on 6/22/16 at 1:00 PM stated the resident had not received oxygen through his CPAP machine. The physician confirmed that he reviewed the orders and should have canceled the order for the oxygen because his oxygen levels were within normal perimeters. Telephone interview with Registered Nurse (RN) #1 on 6/22/16 at 2:20 PM stated the resident never had oxygen with the CPAP machine. Observation in Resident #1's room on 6/22/16 at 7:12 AM revealed the CPAP mask in place and attached to the CPAP machine. Further observation revealed no oxygen attached to the machine and the CPAP setting at 8cm H2O.	F 281	4. a, b, c. DON is responsible for these process change and will be responsible for tracking and trending any issues identified with order entry, medication administration, or following physician orders. If indicated remedial education and/or discipline will be provided. DON will bring findings to QAPI for review and recommendations monthly x 3 months. **Completion Date: August 5, 2016**	

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F 281	Continued From page 5 Interview with Director of Nursing on 6/23/16 at 9:00 AM in the conference room confirmed the order to bleed in 2 LPM of oxygen with the CPAP was not administered. Medical record review of the Physicians Order for Resident #1 dated 11/13/15 revealed original order for Dilantin 125 mg (milligram) /5 ml (milliliter) suspension, give 4 ml (100 mg) per tube every 8 hours. Physician Order dated 11/18/15 revealed taper Dilantin by 125 mg every 2 weeks...administer 175 mg from 12/18/15 through 1/1/16; then administer 50 mg 1/2/16 through 1/16/16 then discontinue. Medical record review of the Physician Order dated 12/30/15 revealed discontinue Dilantin. Medical record review of the December 2015 MAR revealed the onset date of 12/18/15 for Dilantin 125 mg/5 ml suspension, give 4 ml (100 mg) per tube once daily at midnight for 2 weeks. (In addition to the 100 mg give 75 mg in afternoon for two weeks to equal total daily dose of 175 mg) to be administered. Medical record review of the December 2015 MAR revealed Dilantin 175 mg was not administered for 10 days (12/20/15 - 12/29/15). Interview with Director of Nursing on 6/23/16 at 8:35 AM in the conference room confirmed the Dilantin was not administered as ordered by the physician.	F 281		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	**F514** **483.75(i)(1) RESIDENT RECORDS-COMPLETE/ACCURATE/ACCESSIBLE**	

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F 514	Continued From page 6 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and facility policy review, the facility failed to accurately identify the wound site on the care plan and the treatment section on the Medication Administration Record for 1 (Resident #5); failed to accurately document the monitor for bleeding for 1 (Resident #9); failed to accurately document the insulin units administered for 2 (Resident #13, 14); and inaccurately documented the administration of oxygen while on a CPAP (Continuous Positive Airway Pressure) for 1 (Resident #1) of 14 residents reviewed. The findings included: Medical record review revealed Resident #5 was admitted to the facility on 6/2/16 with diagnoses including Acute Hematogenous Osteomyelitis Left Humerus, Diabetes Mellitus Type 2, and Non-Pressure Chronic Ulcer Foot. Medical record review of the Weekly Skin form	F 514	**Plan of correction** 1. a. Treatment orders and care plan were updated for Resident #5 by wound care nurse on 6/8/2016 to accurately reflect wound locations. b. Resident #9 is being monitored every shift for abnormal bleeding. c. Sliding scale insulin order for Resident #13 was data entered correctly by ADON on 6/23/2016 to accurately reflect MD order. d. Sliding scale insulin orders were placed on paper MAR's for all residents receiving sliding scale insulin starting 6/23/2016 through 6/30/2016 when identified problem with EZ-MAR system was corrected to accurately document units of insulin administered. e. Order to administer 2L oxygen per CPAP machine for Resident #1 was discontinued on 6/22/2016.	

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F 514	Continued From page 7 dated 6/2/16 revealed Resident #5 had ulcers identified as Suspected Deep Tissue Injury (SDTI) with one on the right heel and the second on the inner right heel. The third site was identified on the right ankle as an open area. All areas were present upon admission. Medical record review of the Initial Weekly Wound form dated 6/3/16 revealed the following: 1.) Wound Location: Right Heel, Wound Type: SDTI, Wound Measurements (in cm): 1.5 x 1.5 x 0.0. 2.) Wound Location: Right (inner) Heel, Wound Type: SDTI, Wound Measurements (in cm): 1.0 x 1.0 x 0.0. 3.) Wound Location Right Ankle, Wound Type: Pressure Ulcer, Wound Measurements (in cm): 2.0 x 0.03 x 0.01. Medical record review of the care plan dated 6/2/16 revealed the resident "...has pressure ulcers on the lt (left) inner ankle stage 2, lt back heel SDTI, lt side heel SDTI..." Medical record review of the 6/2016 Medication Administration Record (MAR) revealed the following: 1.) "...Clean wound Lt (left) inner ankle..." was treated 6/4/16 through 6/7/16. 2.) "...Clean wound to back of heel (no foot identified)..." was treated on 6/4/16 through 6/7/16. 3.) "...Clean wound Lt back of heel..." had no documentation of treatment. Observation on 6/8/16 at 8:25 AM in Resident #5's room revealed Wound Nurse #1 providing treatment to 3 sites on the right foot/ankle area to Resident #5.	F 514	2. a. Current residents in facility with wounds will be audited by DON and ADON to ensure wound locations are accurately documented in the wound assessment, MD order, and Care plan by 7/15/2016. b. Current residents in facility receiving medications and/or treatments will be audited daily by DON and ADON per omission reports run by nurses prior to end of shift to ensure all medications and treatments are being accurately documented as administered per MD order. c, d. Current residents in facility on sliding scale insulin were audited by DON and ADON on 6/23/2016 to ensure data entered orders were accurate compared to MD orders. e. No other residents in facility have an order to administer/bleed oxygen through CPAP machine.	

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F 514	Continued From page 8 Interview with the Director of Nursing on 6/8/16 at 1:15 PM in the conference room, confirmed the facility failed to maintain an accurate medical record, for the care plan, for the MAR treatment, and for the wound identified on the right heel and ankle. Further interview revealed Wound Nurse #1 had completed the Weekly Skin form, the Initial Weekly Wound form, and the care plan. Interview with Wound Nurse #1 on 6/8/16 at 1:35 PM in the conference room confirmed she had filled out the Weekly Skin form, the Initial Weekly Wound form, and the care plan. Further interview confirmed she had inaccurately identified the wound location on the treatment section of the MAR and the care plan. Medical record review revealed Resident #9 was admitted to the facility on 4/25/16 and readmitted to the facility on 6/16/16 with diagnoses including Acute Osteomyelitis, Morbid Obesity, Chronic Obstructive Pulmonary Disease, and Aortocornonary Bypass Graft. Medical record review of the physician order dated 4/25/16, and was on-going to the present day, revealed "...Monitor of abnormal bleeding: Monitor for bleeding every shift..." Medical record review of the May 2016 Medication Administration Record of the 7:00 AM-7:00 PM shift for monitoring for bleeding every shift failed to document the monitoring 19 out of 31 opportunities on 5/4, 9, 10, 11, 13, 15, 15, 18, 19, 20, 21, 24, 25, 26, 27, 28, 29, 30, and 31/2016.	F 514	3. a. An in-service will be performed by DON and SDC with wound care nurse about accurately identifying and documenting wound locations within MD orders, assessments, and care plans by 7/15/2016. Treatment orders will be reviewed daily in morning meeting by DON and ADON and compared to wound assessment and care plan to ensure wound site accuracy. Audit tool will be developed per by 7/15/2016 per DON to require a signature from 2 nurses verifying wound locations and accurate documentation of these locations. b. An in-service will be conducted by DON and SDC for the RN's and LPN's on staff/all shifts by 8/5/2016 regarding the requirement of running an omission report prior to the end of designated shift to ensure all medications and treatments have been documented as administered per MD orders.	

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F 514	Continued From page 9 Interview with the Director of Nursing, on 6/22/16 at 1:15 PM in the conference room, confirmed the facility failed to accurately document the monitoring for bleeding on the 7:00 AM - 7:00 PM shift in May 2016. Review of the facility policy entitled "Physician Orders", last reviewed on 6/1/15, revealed "...Physician/Medical Practitioner order given (via telephone; directly written in chart; verbal; faxed)...Nurse receiving order is responsible for complete order documentation...Nurse receiving order determines if order is formulary compliant and clarifies variance with Medical Practitioner...Medications placed in EZMAR [computerized Mediation Administration Record] for specific resident by designated Nurse including dosage, medication, route and frequency of administration...Designated Nurse reviews all charts daily to insure no orders were missing..." Review of the undated facility policy entitled "Medication Administration" revealed "...Documentation: The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication given...The resident's MAR...is initialed by the person administering the medication, in the spaces provided under the date, and on the line for the specific dose administered and time..." Medical record review revealed Resident #13 was re-admitted to the facility on 10/8/14 with diagnoses including Below Knee Amputation, Diabetes Mellitus Type 2, and Idioperipheral Neuropathy.	F 514	c, d. Identified EZ-MAR computer program problem has been repaired. Paper MAR's were used between 6/23/2016 and 6/30/2016 for residents requiring sliding scale insulin when program problem was identified, to ensure appropriate documentation of insulin units administered. An in-service was conducted with the RN's and LPN's on staff/all shifts by DON and SDC on 6/23/2016 regarding the implementation of paper MAR use for those residents on sliding scale insulin. e. An in-service will be performed by DON and SDC with the RN's and LPN's on staff/all shifts by 8/5/2016 regarding following MD orders, medication administration, documentation, and CPAP/BiPAP use to ensure documentation accurately reflects MD orders.	

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F 514	Continued From page 10 Medical record review of the physician orders revealed the following: 1. On 7/22/15 and ongoing to the present, an order for "...Accuchecks (blood sugar level monitoring) before meals and at bedtime on Mondays, Thursdays, and Saturdays..." 2. On 7/22/15 and ongoing to the present, an order for "...Accuchecks as needed..." 3. On 5/27/15 and ongoing to the present, an order for sliding scale insulin of "...Novolog...Insulin inject sub-q [subcutaneous] according to scale before meals and at bedtime on Mon [Mondays], Thurs [Thursdays], and Sat [Saturdays]..." with specific units to be administered pending the result of the accucheck. Medical record review of the MARs for the sliding scale insulin administration and the accucheck results revealed the facility failed to consistently document the units of insulin administered per the out of range accucheck results as followed: 1. There were a total of 12 opportunities (first week of each month for a total of 3 days) documented for sliding scale insulin administration in November and December 2015, April, May and June 2016. After the first 3 days of the month there was no documentation of the sliding scale insulin administration. 2. On November 2015 of the 52 opportunities with 21 refusals for the accucheck - of the 31 opportunities remaining -11 entries required insulin administration for out of range accucheck, and 5 entries lacked documentation of the accucheck and/or required insulin if needed. 3. On December 2015 of the 52 opportunities with 20 refusals for the accucheck - of the 32 opportunities remaining - 8 entries required insulin administration for out of range accucheck,	F 514	4. a. Treatment orders will be reviewed daily during clinical meeting by DON and ADON, then compared to wound assessment and care plan to ensure wound location is accurately identified. Audit tool will be used that will require two nurses' signatures for any identified wounds, to ensure wound location has been accurately identified and documented in the medical record. Findings will be taken to QAPI by DON for review and recommendations monthly x 3 months. b. Omission reports will be reviewed daily during clinical meeting by DON and ADON to ensure medications and treatments are being documented as administered as per MD orders. DON will track and trend these reports and take to QAPI for review and recommendations monthly x 3 months.	

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	445075	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF MADISON	431 LARKIN SPRING RD MADISON, TN 37115

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F 514	Continued From page 11 and 4 entries lacked documentation of the accucheck and/or required insulin if needed. 4. On April 2016 of the 52 opportunities with 12 refusals for the accucheck - of the 40 opportunities remaining - 8 entries required insulin administration for out of range accucheck, and 4 entries lacked documentation of the accucheck and/or required insulin if needed. 5. On May 2016 of the 52 opportunities - 28 entries required insulin administration for out of range accucheck, and 5 entries lacked documentation of the accucheck and/or required insulin if needed. 6. On June 1-23, 2016 up to 8:00 AM of the 37 opportunities - 25 entries required insulin administration for out of range accucheck. Medical record review revealed Resident #14 was admitted to the facility on 2/15/16 with diagnoses including Above Knee Amputation, Diabetes Mellitus Type 2, and Pressure Ulcer. Medical record review of the physician orders revealed the following: 1. On 2/15/16 and ongoing to the present for "...Accuchek [Accucheck] SQ [subcutaneous] ACHS [before meals and bedtime]..." 2. On 2/15/16 and ongoing to the present for "...Accuchek SQ as needed..." 3. on 2/15/16 and ongoing to the present for sliding scale insulin of "...Humolog...Insulin inject sub-q four times daily before meals & [and] at bedtime..." with specific units to be administered pending the result of the accucheck. Medical record review of the MARs revealed the facility failed to consistently document the units of insulin administered per the out of range accucheck results as followed:	F 514	c, d. DON and ADON will audit MAR's of current residents receiving sliding scale insulin daily to ensure that units of insulin administered are correctly documented on MAR x 30 days, then monthly x 3 months. DON will take findings to QAPI for review and recommendations monthly x 3 months. e. New orders will be reviewed daily during clinical	

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F 514	Continued From page 12 1. On April 2016 of the 117 opportunities - 48 entries lacked insulin units administered for out of range accucheck, and 3 entries lacked documentation. 2. On May 2016 of the 124 opportunities - 47 entries lacked insulin units administered for out of range accucheck, 1 entry lacked documentation, and 1 entry was a REFUSED. 3. On June 1-23, 2016 up to 8:00 AM of the 89 opportunities - 23 entries lacked insulin units administered for out of range accucheck. Interview with the Director of Nursing and the Corporate Clinical Consultant,on 6/23/16 beginning at 1:20 PM in the conference room, confirmed the facility failed to follow the facility policy to correctly data enter the physician order into the EZMAR and failed to consistently document in the EZMAR the units of insulin administered pending the result of the accucheck for Residents #13 and 14. Medical record review revealed Resident #1 was admitted to the facility on 12/17/14 and re-admitted on 11/13/15 with diagnoses of Adult Failure to Thrive, Dementia, Diabetes Type 2, Muscle Weakness, Dysphagia, Aphasia, Gastrostomy, Hemiplegia following Cerebral Vascular Disease, and Hypertension. Medical record review of the Physicians Order dated 1/20/15 revealed an order for "...CPAP (Continuous Positive Airway Pressure) 8 cm (centimeters) H2O (water), Bleed in O2 (oxygen) at 2 LPM (liters per minute) while sleeping..." Medical record review of the MAR dated 9/1/2015 revealed an order for CPAP 8 cm H2O, Bleed in	F 514	meeting by DON and ADON to ensure accuracy of data entry in EZ-MAR system. New CPAP/BiPAP orders will be reviewed daily during clinical meeting by DON and ADON to ensure accuracy and identification of need to bleed oxygen per CPAP/BiPAP. If applicable, audit will be conducted by DON and ADON to verify that oxygen is available and being administered per CPAP as ordered. DON will take findings to QAPI for review and recommendations monthly x 3 months. **Completion Date: August 5, 2016**	

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F 514	Continued From page 13 O2 at 2 LPM while sleeping. The MAR was initialed as administered daily with O2. Interview with LPN (Licensed Practical Nurse) #3 on 6/22/16 at 9:25 AM at the East nurses station stated that he wasn't sure if the resident had oxygen on his CPAP. Telephone interview with the daughter on 6/22/16 at 9:47 AM stated Resident #1 never received oxygen through the CPAP machine. Telephone interview with LPN #1 on 6/22/16 at 10:45 AM stated the resident never received O2 with the CPAP since she started to work here in 5/2016. Telephone interview with LPN #4 on 6/22/16 at 11:30 AM stated the resident never received O2 with the CPAP machine. Telephone interview with the facility physician 6/22/16 at 1:00 PM stated the resident never received oxygen through his CPAP machine. The physician confirmed that he reviewed the orders and should have canceled the order for the oxygen. Telephone interview with Registered Nurse (RN) #1 on 6/22/16 at 2:20 PM stated the resident never had oxygen with the CPAP machine. Observation in Resident #1's room on 6/22/16 at 7:12 AM revealed the CPAP mask in place and attached to the CPAP machine. Further observation revealed no oxygen attached to the machine and the CPAP setting at 8cm H2O. Interview with Director of Nursing on 6/23/16 at	F 514		

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F 514	Continued From page 14 9:00 AM in the conference room confirmed the facility failed to maintain accurate medical records.	F 514		